Washington State Health Care Authority

It's easier online
Use the *2015 Spousal Plan Calculator* at **www.hca.wa.gov/pebb**.

2015 Spousal Plan Calculator

Clear Form

Subscriber's last name	First name	Middle initial	Social Security number

If you answered "YES" to all the questions in the *2015 Premium Surcharge Help Sheet*, complete this calculator and send it to your employer (for employees) or the PEBB Program (for COBRA, LWOP, and non-Medicare retirees) with your 2015 enrollment form or *2015 Premium Surcharge Change Form*.

Use the *Summary of Benefits and Coverage* from your spouse's or registered domestic partner's employer-based group medical insurance plan(s) to answer the questions below. Do not return the *Summary of Benefits and Coverage* with this form.

The plan(s) must:

- Serve your spouse's or registered domestic partner's county of residence, **and**
- Cost less than $89.31 for the employee's share of the monthly premium.

Complete a *2015 Spousal Plan Calculator* for **each** medical plan that meets the criteria above. If you have more than one plan that meets the criteria above, copy this form as needed and submit a form for **each** plan. (If you are entering more than one plan, and at least one results in "You will have to pay the surcharge," then you will have to pay the surcharge.)

For question 1A, look at the top-right corner of the *Summary of Benefits and Coverage* next to **Plan Type**.

1 Is this a high-deductible health plan (HDHP) or a consumer-driven health plan (CDHP)?
If the Plan Type is HMO, PPO, or POS, check "NO."

A. ❑ YES ❑ NO

B. If YES, how much does the employer contribute each year for an individual's health savings account (HSA) or health reimbursement account (HRA)?

$ _____

For questions 2 and 3, look at the *Summary of Benefits and Coverage* under "Important Questions."
Only look at amounts for a **single person** (or individual) using a **preferred** (or in-network) provider.

2 How much is/are the plan's deductible(s)?
Answer either A or B. Don't answer both.

A. $ _____ Overall deductible (if you only see one deductible for the plan), **OR**

B1. $ _____ Medical deductible, **AND**

B2. $ _____ Prescription drug deductible

3 How much is/are the plan's out-of-pocket limit(s)?
Answer either A or B. Don't answer both

A. $ _____ Out-of-pocket limit (if you only see one out-of-pocket limit for the plan), **OR**

B1. $ _____ Medical out-of-pocket limit, **AND**

B2. $ _____ Prescription drug out-of-pocket limit

For questions 4 through 7, look at the Summary of Benefits and Coverage under "Common Medical Events" and "Services You May Need." Only look at amounts for a **single person** (or individual) using a **preferred** (or in-network) provider.

4 What is the plan's most common coinsurance among these three services: 1) Primary care visit to treat an injury or illness, 2) Diagnostic test, and 3) Durable medical equipment?

- If you see the same coinsurance (%) for at least two of these services, write that amount.
- If you see different coinsurance amounts, or copays ($) with coinsurance, write the highest coinsurance amount you see.
- If you only see copays ($) for all three services, skip this question.

_____ %

5 How much is the plan's copay for a primary care visit to treat an injury or illness?

Skip this question if you see:

- Only coinsurance (%), **OR**
- Copay ($) and coinsurance (%).

$ _____

6 How much is the plan's copay for emergency room services?

Skip this question if you see:

- Only coinsurance (%), **OR**
- Copay ($) and coinsurance (%).

$ _____

7 How much is the plan's coinsurance or copay for preferred brand drugs (or formulary drugs)?

Answer either A or B. Don't answer both

A. _____ % Coinsurance, **OR**

B. $ _____ Copay

Signature

By signing this form, I declare that the information I have provided is true, complete, and correct. If it isn't, or if I do not provide timely, updated information, I will owe surcharges to the PEBB Program.

HCA's Privacy Notice: We will keep your information private as allowed by law.
To see our Privacy Notice, go to **www.hca.wa.gov/pebb**.

Name (print)_____ Last four digits of Social Security number _____

Signature _____ Date _____

Agency name (employees only) _____

Please sign and date this form.

If you're:	**Return it to:**
An employee	Your personnel, payroll, or benefits office.
Any other subscriber	PEBB Program Washington State Health Care Authority P.O. Box 42684 Olympia, WA 98504-2684 or fax to: 360-725-0771

ABC Insurance: Example Plan

Summary of Benefits and Coverage: What This Plan Covers and What It Costs

Coverage Period: 01/01/2014-12/31/2014
Coverage for: XXXX | Plan Type: ❶A

Important Questions	Answers	Why This Matters:
What is the overall deductible?	❷**A or** ❷**B1**/person, **$XXX**/family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1).
Are there other deductibles for specific services?	Yes. ❷**B2** for prescription drug coverage.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes. ❸**A or** ❸**B1**/person, **$XXX**/family. Prescription drugs: ❸**B2**	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, **prescription drugs,** balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.

• • •

Common Medical Event	Services You May Need	Your Cost If You Use An In-network Provider	Your Cost If You Use An Out-of-network Provider	Limitations and Exceptions
If you visit a health care provider's office or clinic	**Primary care visit to treat an injury or illness**	❹ ❺	X% co-insurance	——————none——————
	Specialist visit	$X co-pay	X% co-insurance	——————none——————
	Other practitioner office visit	$X co-pay	X% co-insurance	——————none——————
	Preventive care/screening/immunization	No charge	X% co-insurance	——————none——————
If you have a test	**Diagnostic test (x-ray, blood work)**	❹	X% co-insurance	——————none——————
	Imaging (CT/PET scans, MRIs)	$ X% co-insurance	X% co-insurance	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use An In-network Provider	Your Cost If You Use An Out-of-network Provider	Limitations and Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.example.com.	Generic drugs	$X co-pay	X% co-insurance	——————none——————
	Preferred brand drugs	❼A or ❼B	X% co-insurance	——————none——————
	Non-preferred brand drugs	$X co-pay	X% co-insurance	——————none——————
	Specialty drugs	$X co-pay	X% co-insurance	——————none——————
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	X% co-insurance	X% co-insurance	——————none——————
	Physician/surgeon fees	X% co-insurance	X% co-insurance	——————none——————
If you need immediate medical attention	**Emergency room services**	❻	X% co-insurance	——————none——————
	Emergency medical transportation	X% co-insurance	X% co-insurance	——————none——————
	Urgent care	X% co-insurance	X% co-insurance	——————none——————

• • •

If you need help recovering or have other special health needs	Home health care	X% co-insurance	X% co-insurance	——————none——————
	Rehabilitation services	X% co-insurance	X% co-insurance	——————none——————
	Habilitation services	X% co-insurance	X% co-insurance	——————none——————
	Skilled nursing care	X% co-insurance	X% co-insurance	——————none——————
	Durable medical equipment	❺	X% co-insurance	——————none——————
	Hospice service	X% co-insurance	X% co-insurance	——————none——————